

ASSEMBLY BILL

No. 977

Introduced by Assembly Member Nava

February 18, 2005

An act to add Section 1375 to the Health and Safety Code, and to add Section 10191.5 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 977, as introduced, Nava. Health care review process.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime. Existing law provides for the licensure and regulation of health insurers by the Department of Insurance.

This bill would require a health care service plan and a health insurer to apply, respectively, to the Director of the Department of Managed Health Care and the Insurance Commissioner for approval to charge a deductible, copayment, or other out-of-pocket cost or to impose a limitation on benefits or coverage. The bill would require the director and commissioner to obtain public comment before deciding on the application and would specify factors the director or commissioner must consider in deciding on the application. The bill would require the director and commissioner to develop a schedule and process to also review existing plan contracts and policies, as specified.

Because the bill would specify additional requirements for health care service plans, the violation of which would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1375 is added to the Health and Safety
2 Code, to read:

3 1375. (a) A health care service plan shall apply to the director
4 before charging an enrollee or subscriber a deductible,
5 copayment, or other out-of-pocket cost or before imposing a
6 limitation on benefits or coverage. The director may approve or
7 deny the application or approve it with conditions consistent with
8 this section. A plan shall submit an application for each product
9 that it markets in the individual market, small group market, and
10 other group markets.

11 (b) The director shall provide public notice and seek public
12 comment on the application at least 60 days prior to deciding its
13 disposition. The director shall conduct one or more public
14 meetings to receive public testimony. The director may extend
15 the 60-day period if additional information or factors are brought
16 to his or her attention. In no instance shall the review period
17 exceed 365 days from the date of the public notice.

18 (c) (1) The information provided to the public for review
19 pursuant to subdivision (b) shall include the proposed plan
20 contract as well as the proposed disclosures, if any, required
21 pursuant to Sections 1363 and 1363.06. For products not subject
22 to those sections, the information provided to the public for
23 review shall include a uniform health plan benefits and coverage
24 matrix containing the plan's major provisions in order to
25 facilitate comparisons between plan contracts. The uniform
26 matrix shall include the following category descriptions, together
27 with the corresponding copayments and limitations, in the
28 following sequence:

29 (A) Deductibles.

- 1 (B) Lifetime maximums.
- 2 (C) Professional services.
- 3 (D) Outpatient services.
- 4 (E) Hospitalization services.
- 5 (F) Emergency health coverage.
- 6 (G) Ambulance services.
- 7 (H) Prescription drug coverage.
- 8 (I) Durable medical equipment coverage.
- 9 (J) Mental health services.
- 10 (K) Chemical dependency services.
- 11 (L) Home health services.
- 12 (M) Other benefits or limitations.
- 13 (2) Nothing in this section shall prevent a plan from using
- 14 appropriate footnotes or disclaimers to reasonably and fairly
- 15 describe coverage arrangements in order to clarify any part of the
- 16 matrix that may be unclear.
- 17 (d) The director shall consider the following factors in
- 18 determining whether to approve an application or to deny or
- 19 approve it with conditions:
- 20 (1) The type and number of enrollees that are affected or who
- 21 are potentially affected by it.
- 22 (2) The implication of limitations and exclusions for clinical
- 23 efficacy.
- 24 (3) The availability of therapeutic equivalents or other
- 25 approaches for medically appropriate care or treatment.
- 26 (4) The specific services to which the copayment, coinsurance,
- 27 deductible, limitation, or exclusion will apply.
- 28 (5) The duration of the limitation or exclusion, if any.
- 29 (6) The rationale for the copayment, coinsurance, deductible,
- 30 limitation, or exclusion.
- 31 (7) The projected effect of the copayment, coinsurance,
- 32 deductible, limitation, or exclusion on the affordability and
- 33 accessibility of coverage for the enrollee.
- 34 (8) The projected comparative clinical effect, including any
- 35 potential risk of adverse health outcomes, based upon utilization
- 36 data and review of peer-reviewed professional literature.
- 37 (9) Whether the copayment, coinsurance, or deductible
- 38 contributes to the overall out-of-pocket maximum for the
- 39 product.

1 (10) Information regarding similar copayments, coinsurance
2 levels, deductibles, limitations, or exclusions previously
3 approved by the department.

4 (11) Evidence-based clinical studies and professional
5 literature.

6 (12) Any other historical, statistical, or other information that
7 the applicant plan considers pertinent to the request for approval
8 of the copayment, coinsurance level, deductible, limitation, or
9 exclusion.

10 (e) The director shall require a plan to provide information
11 with its application as may be necessary for the department to
12 comply with this section.

13 (f) The director shall develop a schedule and process for the
14 review of existing benefit designs to assure that products
15 covering 90 percent or more of the enrollees or subscribers are
16 reviewed consistent with this section.

17 SEC. 2. Section 10191.5 is added to the Insurance Code, to
18 read:

19 10191.5. (a) An insurer, as described in subdivision (b) of
20 Section 106, shall apply to the commissioner before charging an
21 insured a deductible, copayment, or other out-of-pocket cost or
22 before imposing a limitation on benefits or coverage. The
23 commissioner may approve or deny the application or approve it
24 with conditions consistent with this section. An insurer shall
25 submit an application for each product that it markets in the
26 individual market, small group market, and other group markets.

27 (b) The commissioner shall provide public notice and seek
28 public comment on the application at least 60 days prior to
29 deciding its disposition. The commissioner shall conduct one or
30 more public meetings to receive public testimony. The
31 commissioner may extend the 60-day period if additional
32 information or factors are brought to his or her attention. In no
33 instance shall the review period exceed 365 days from the date of
34 the public notice.

35 (c) (1) The information provided to the public for review
36 pursuant to subdivision (b) shall include the proposed policy as
37 well as the proposed disclosures, if any, required under existing
38 law. For products not subject to disclosure under existing law,
39 the information provided to the public shall include a uniform
40 health policy benefits and coverage matrix containing the

1 policy's major provisions in order to facilitate comparisons
2 between insurer policies. The uniform matrix shall include the
3 following category descriptions, together with the corresponding
4 copayments and limitations, in the following sequence:

- 5 (A) Deductibles.
- 6 (B) Lifetime maximums.
- 7 (C) Professional services.
- 8 (D) Outpatient services.
- 9 (E) Hospitalization services.
- 10 (F) Emergency health coverage.
- 11 (G) Ambulance services.
- 12 (H) Prescription drug coverage.
- 13 (I) Durable medical equipment.
- 14 (J) Mental health services.
- 15 (K) Chemical dependency services.
- 16 (L) Home health services.
- 17 (M) Other benefits or limitations.

18 (2) Nothing in this section shall prevent an insurer from using
19 appropriate footnotes or disclaimers to reasonably and fairly
20 describe coverage arrangements in order to clarify any part of the
21 matrix that may be unclear.

22 (d) The commissioner shall consider the following factors in
23 determining whether to approve an application or to deny or
24 approve it with conditions:

25 (1) The type and number of insureds that are affected or who
26 are potentially affected by it.

27 (2) The implication of limitations and exclusions for clinical
28 efficacy.

29 (3) The availability of therapeutic equivalents or other
30 approaches for medically appropriate care or treatment.

31 (4) The specific services to which the copayment, coinsurance,
32 deductible, limitation, or exclusion will apply.

33 (5) The duration of the limitation or exclusion, if any.

34 (6) The rationale for the copayment, coinsurance, deductible,
35 limitation, or exclusion.

36 (7) The projected effect of the copayment, coinsurance,
37 deductible, limitation, or exclusion on the affordability and
38 accessibility of coverage for the insured.

1 (8) The projected comparative clinical effect, including any
2 potential risk of adverse health outcomes, based upon utilization
3 data and review of peer-reviewed professional literature.

4 (9) Whether the copayment, coinsurance, or deductible
5 contributes to the overall out-of-pocket maximum for the
6 product.

7 (10) Information regarding similar copayments, coinsurance
8 levels, deductibles, limitations, or exclusions previously
9 approved by the department.

10 (11) Evidence-based clinical studies and professional
11 literature.

12 (12) Any other historical, statistical, or other information that
13 the applicant considers pertinent to the request for approval of
14 the copayment, coinsurance level, deductible, limitation, or
15 exclusion.

16 (e) The commissioner shall require an insurer to provide
17 information with its application as may be necessary for the
18 department to comply with this section.

19 (f) The commissioner shall develop a schedule and process for
20 the review of existing benefit designs to assure that products
21 covering 90 percent or more of the insureds are reviewed
22 consistent with this section.

23 SEC. 3. No reimbursement is required by this act pursuant to
24 Section 6 of Article XIII B of the California Constitution because
25 the only costs that may be incurred by a local agency or school
26 district will be incurred because this act creates a new crime or
27 infraction, eliminates a crime or infraction, or changes the
28 penalty for a crime or infraction, within the meaning of Section
29 17556 of the Government Code, or changes the definition of a
30 crime within the meaning of Section 6 of Article XIII B of the
31 California Constitution.